Cardiac Catheterization Survey Parts A-C for 1/1/2006-12/31/2006

Part A: General Information

Georgia Department of Community Health

1. Identification:

Due Date: April 13, 2007

Year: 2006

UID: HOSP542

Facility UID					
a. Facility Name		b. County			
c. Street Address		d. City		e. Street Zip	
f. Mail Address		g. City		h. Mail Zip	
i. Medicaid Provider Number		j. Medicare Provider Number			

2. Report Period:

Report data for the full 12-month period, January 1, 2006 through December 31, 2006 (365 days). Do not use a different report period.

Check the box to the right if your facility was NOT operational for the entire year. ☐

If your facility was NOT operational for the entire year, provide the dates the facility was operational below:

Part B: Survey Contact Person

Person authorized to respond to inquiries about the responses to this survey:

Name		Title			
Telephone		Fax		E-mail	

Part C: Catheterization Procedure Rooms

1A. Please report the total number of Cardiac Catheterization services labs or rooms. Include all labs or rooms that are authorized to provide cardiac catheterizations pursuant to Rule 111-2-2-21. Include both general purpose and dedicated rooms or labs. 0

Room Detail:

1B. Please provide details on each of the labs or rooms reported in 1A above. Report each lab or room on a separate row. The name of the lab or room should be the name used in your facility

Room Name	Operational Date	Dedicated Room?	# of Cath Procedures	If Dedicated What Type?
x		No	0	

1C. Other Rooms - If your facility has other rooms that are equiped and capable of performing a cardiac catheterization (other than what is reported in Part C, Q1 A and B above) please indicate the number of those other rooms below.

Number of other rooms that are equiped and capable of performing cardiac catheterization 0

Please go to Part C (continued)